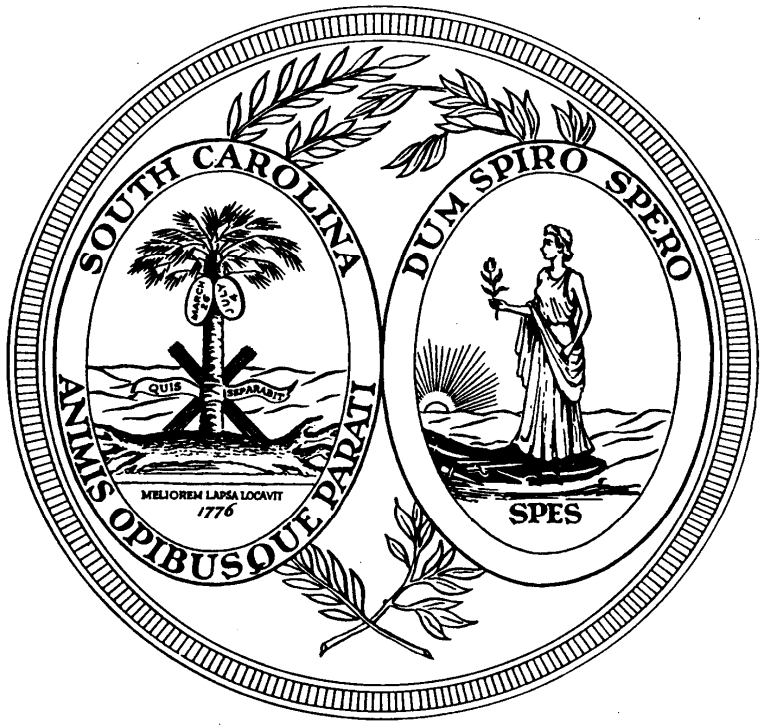


South Carolina Department of Health and Human Services

Community Long Term Care General Session

June 2009

www.scdhhs.gov

Community Long Term Care

- Agenda
  - Introduction
  - State of CLTC
  - Contract/Scopes Changes
  - DDSN Update
  - Additional Edits
  - Provider Compliance

Community Long Term Care

- Agenda
  - Care Call Review
  - Referral/Authorization Process
  - Questions and Comments
  - Adult Day Services Association Discussion

State of CLTC

- Budget Update
- 2007 vs. 2009
- CLTC Providers
- Statewide Waiting List

State of CLTC

- Budget
  - CLTC is trying to maintain the census and services we have had this year.
  - In the last two years, the program has grown both in services provided and in numbers served.

State of CLTC

- Budget
  - As the program has grown, the budget has increased by over $20 million.
  - The major goal at this time is to not lose ground.

State of CLTC

2007	vs.	2009
■ 500 new slots		■ No new slots
■ New services and increases in levels of existing services		■ No new services and some possibility of reductions
■ Evaluating the need for increases in service levels		■ Trying to maintain service levels

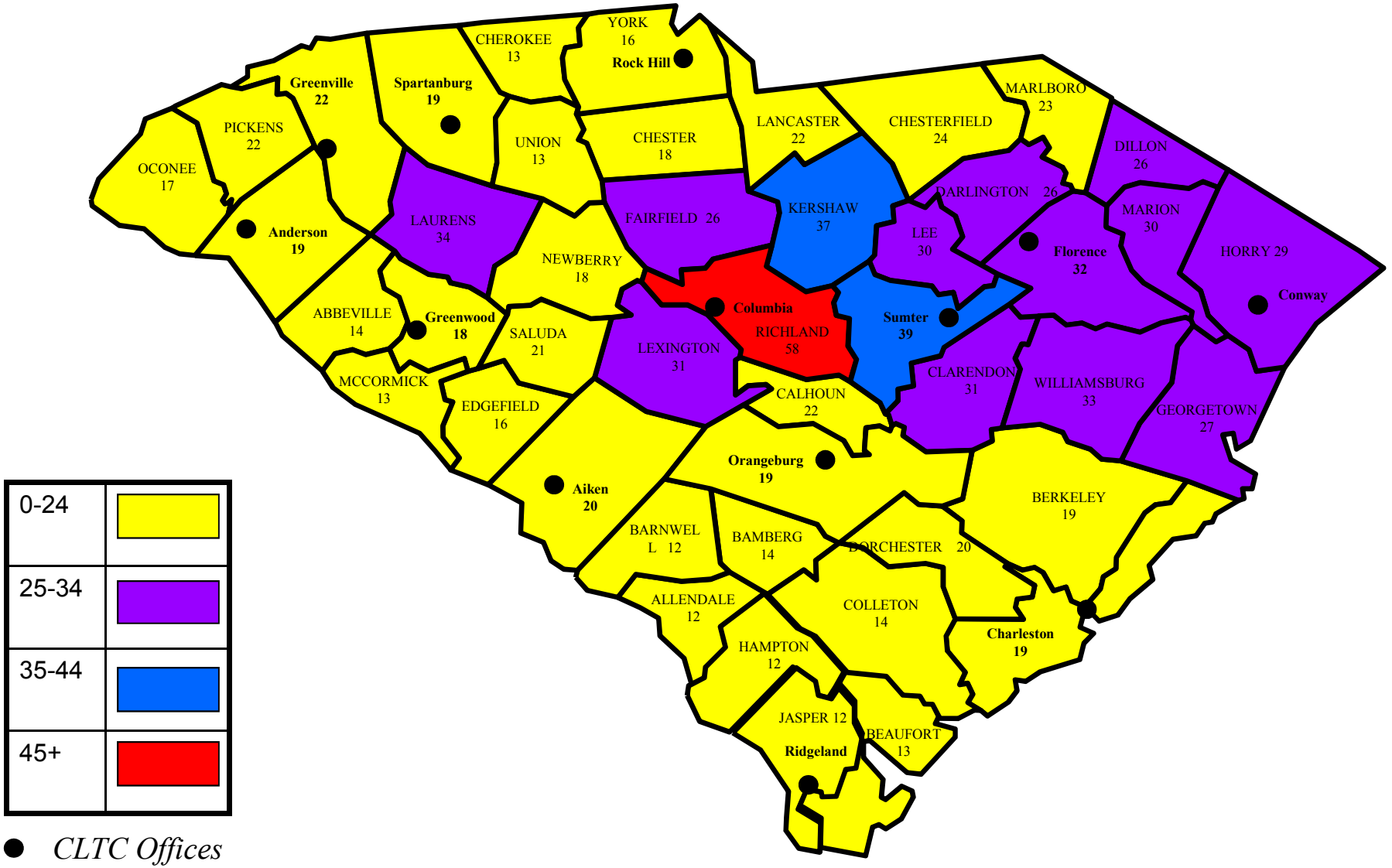
State of CLTC

2007	vs.	2009
▪ Numerous rate increases		▪ No rate increase and trying not to decrease rates
▪ Working toward program improvement		▪ Working toward program improvement

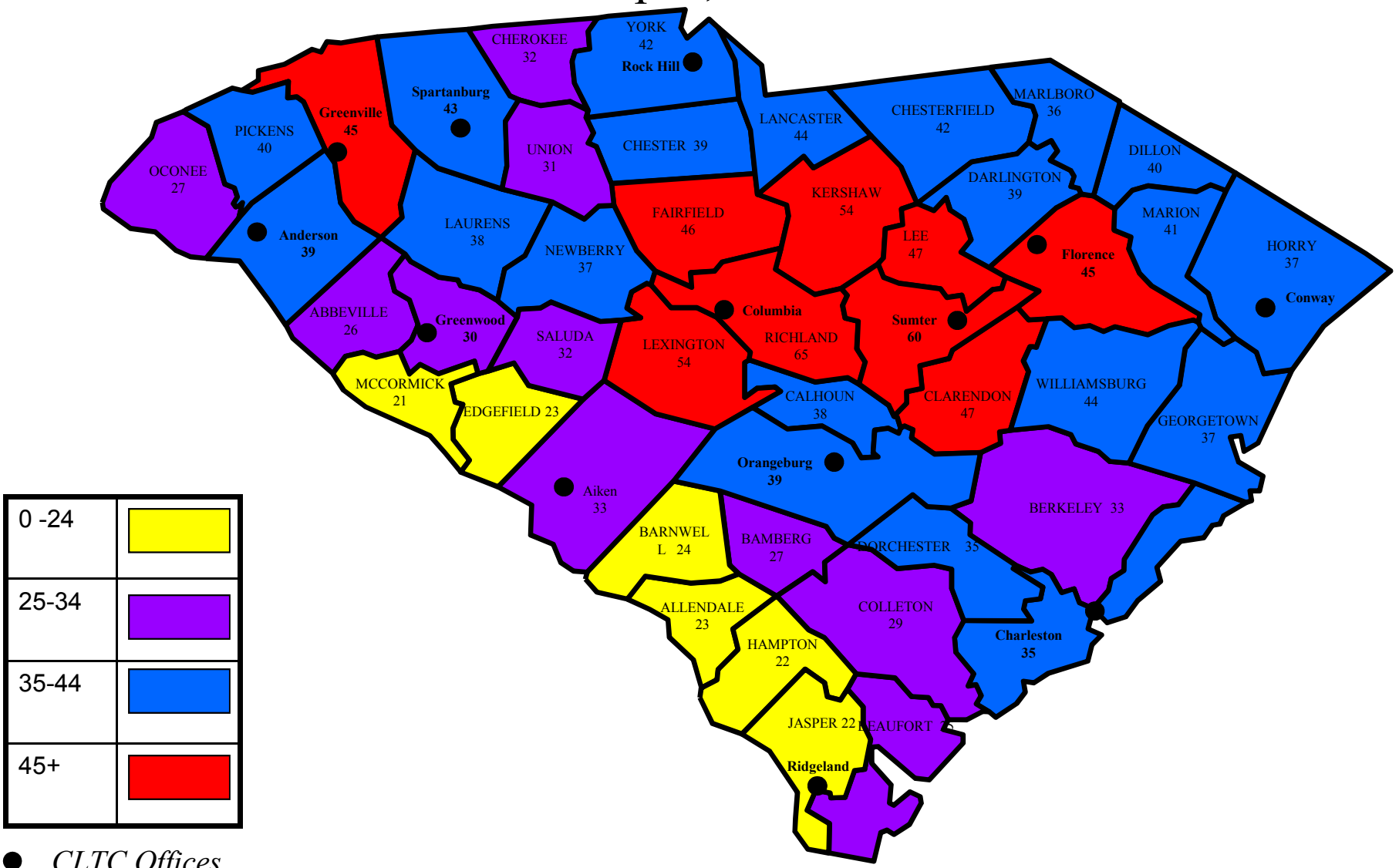
State of CLTC

- CLTC Providers
  - The last two years have seen considerable growth in the number of CLTC providers.
  - This has affected personal care, adult day care and even home delivered meals.
  - This increase is occurring at a time when waiver programs are not growing, meaning that referrals are being spread across a larger number of providers.

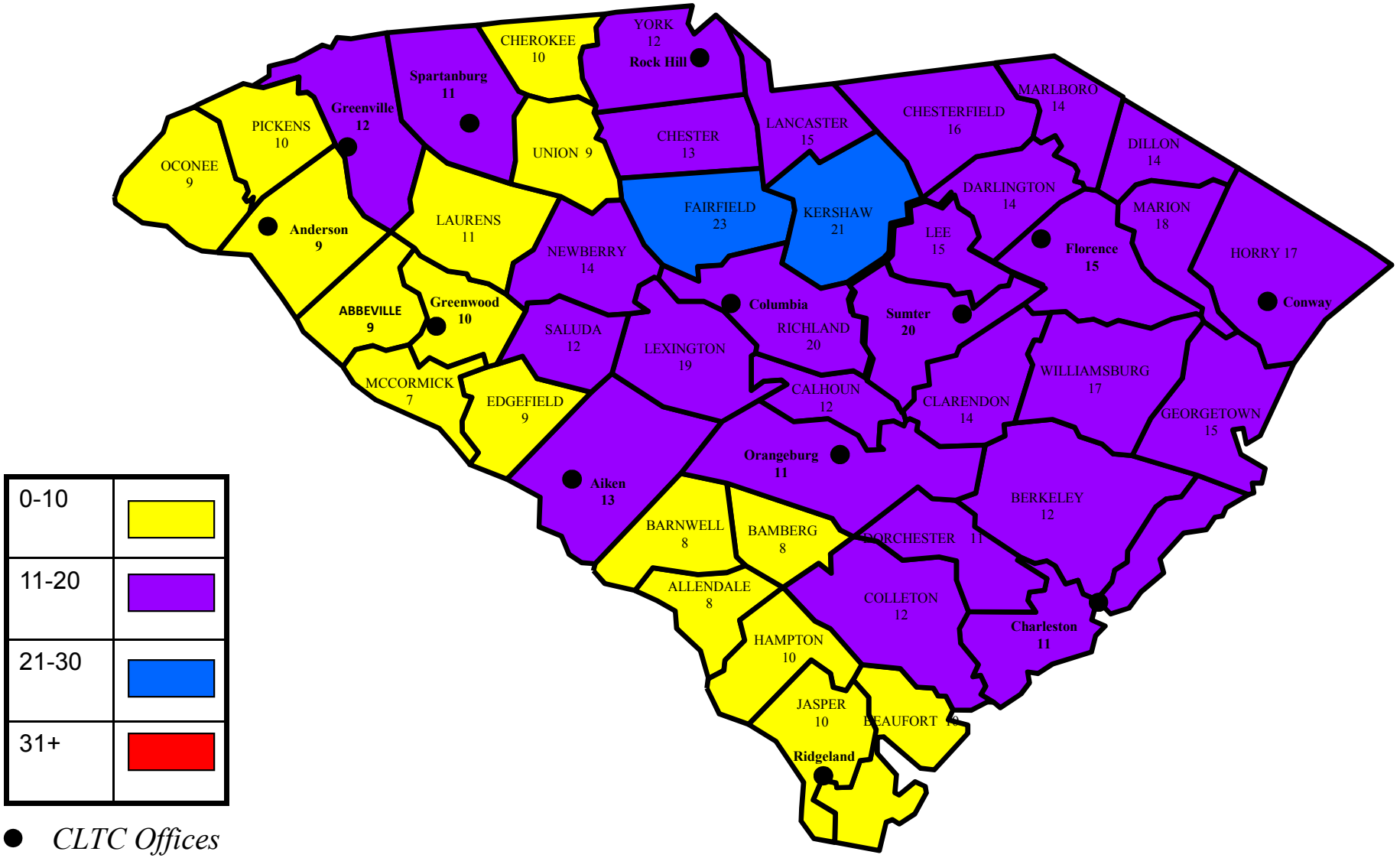
PERSONAL CARE I, II and Companion Providers
May, 2007



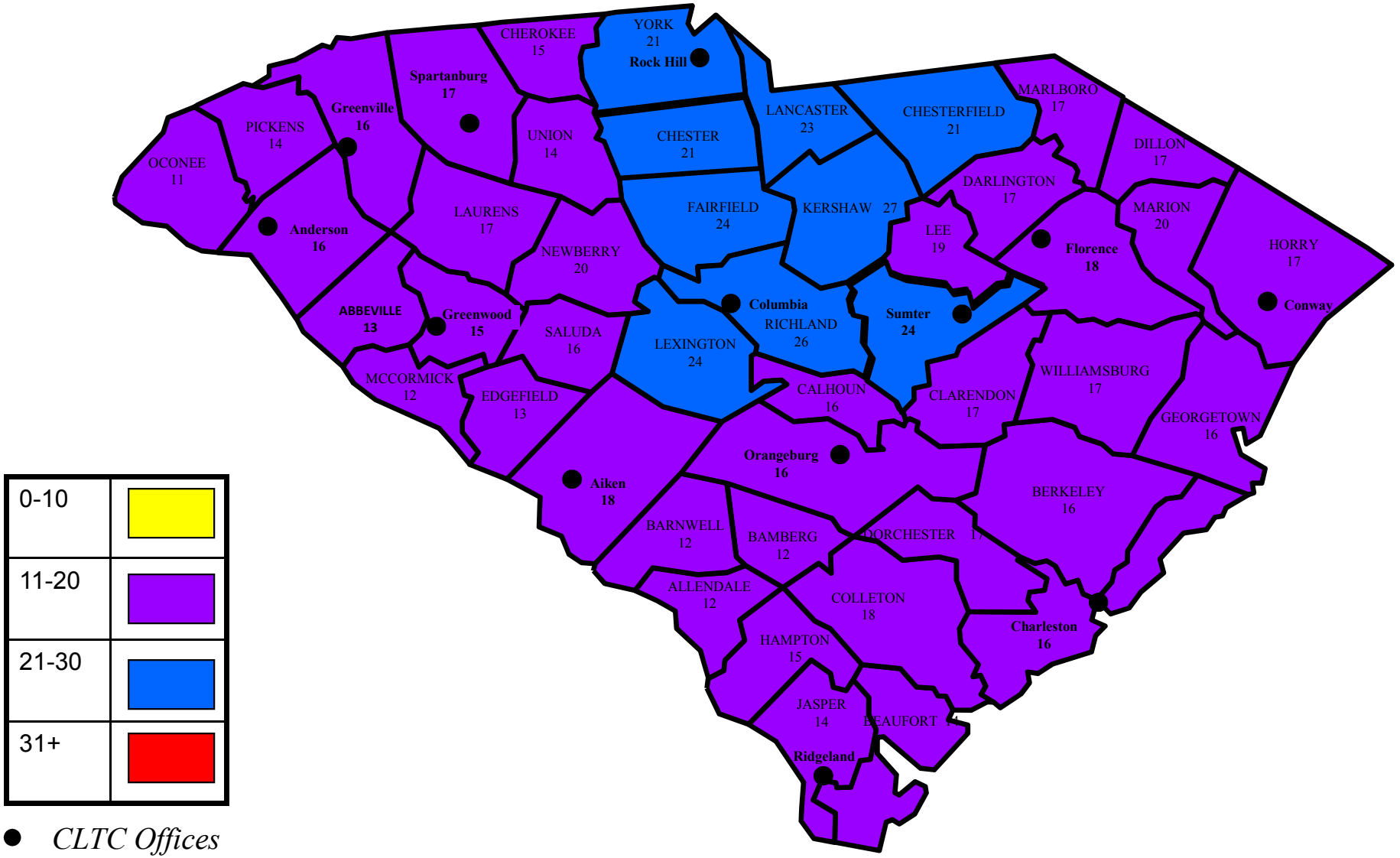
PERSONAL CARE I, II and Companion Providers
April, 2009



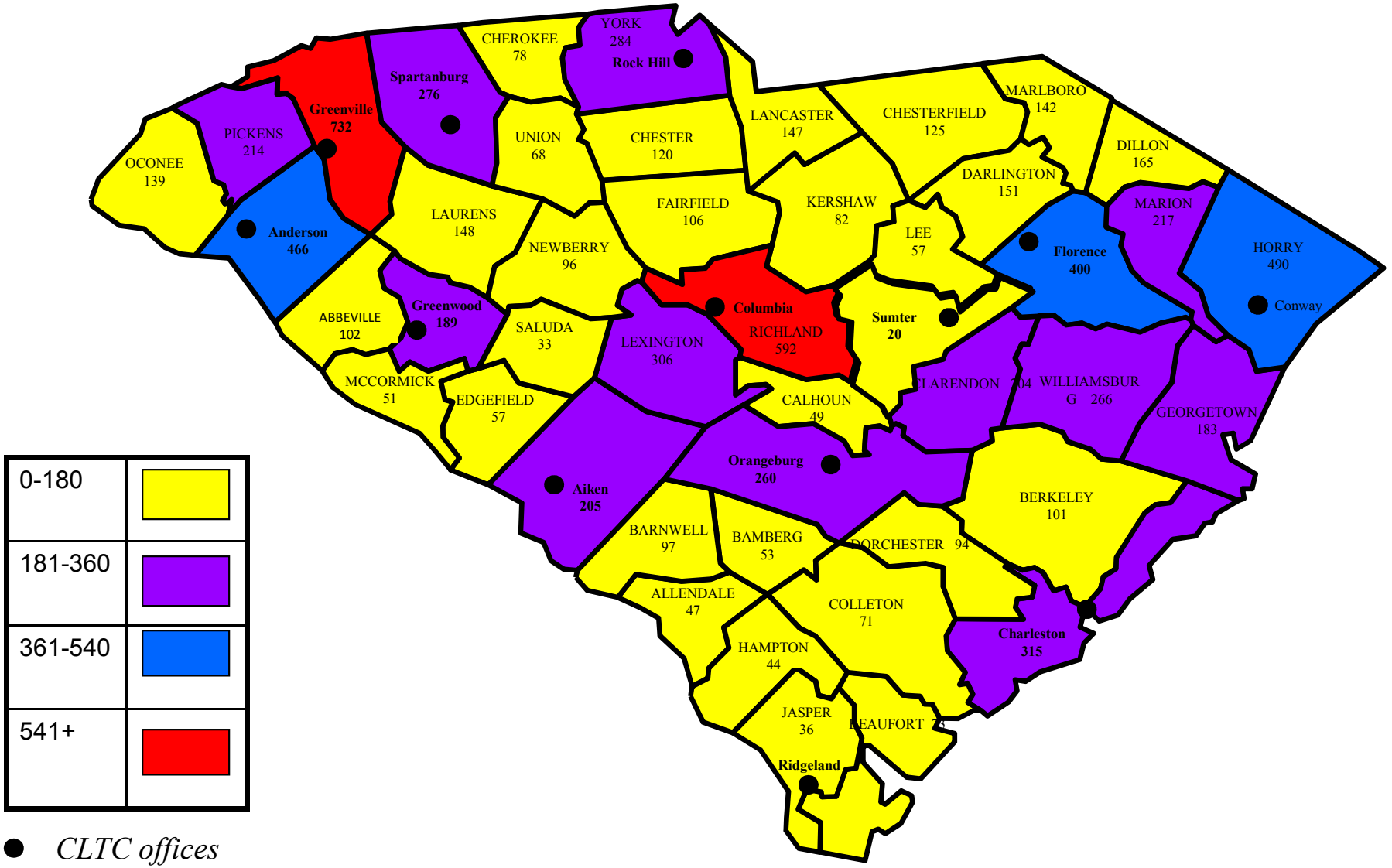
NURSING PROVIDERS
May 2007



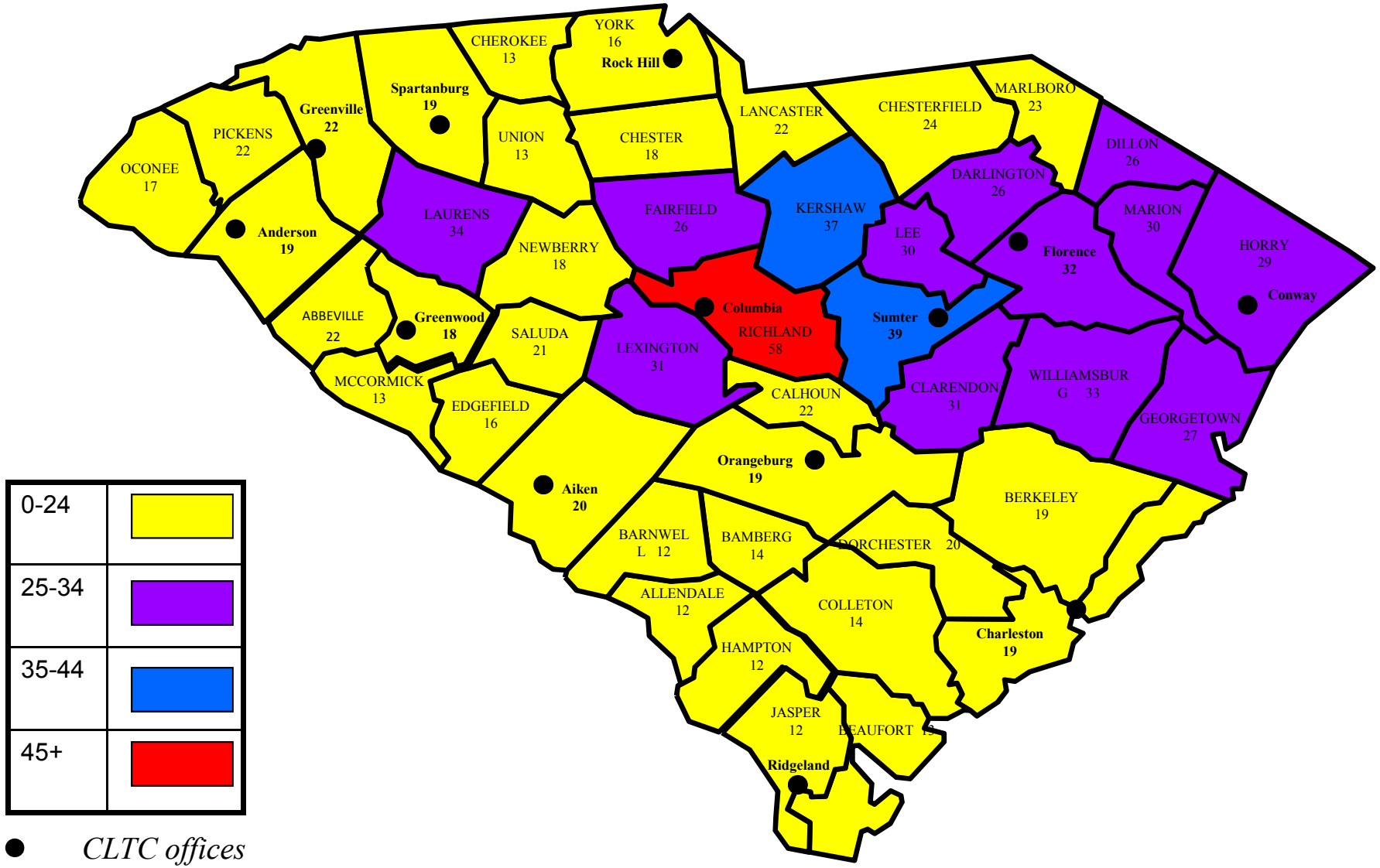
NURSING PROVIDERS
April 2009



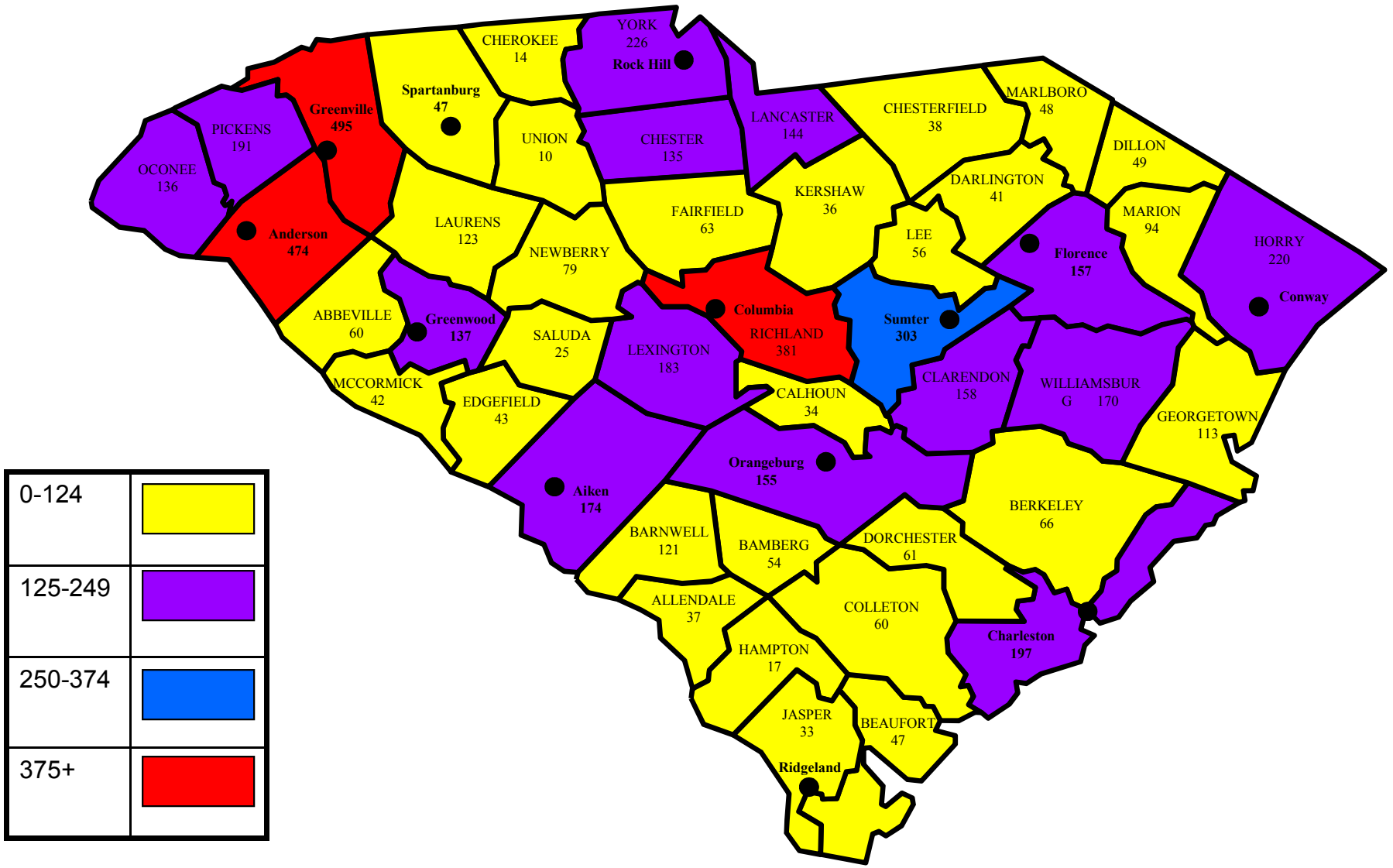
Open Authorization – PC I, II, & Companion - April 2009



Open Authorization - Day Care - April 2009

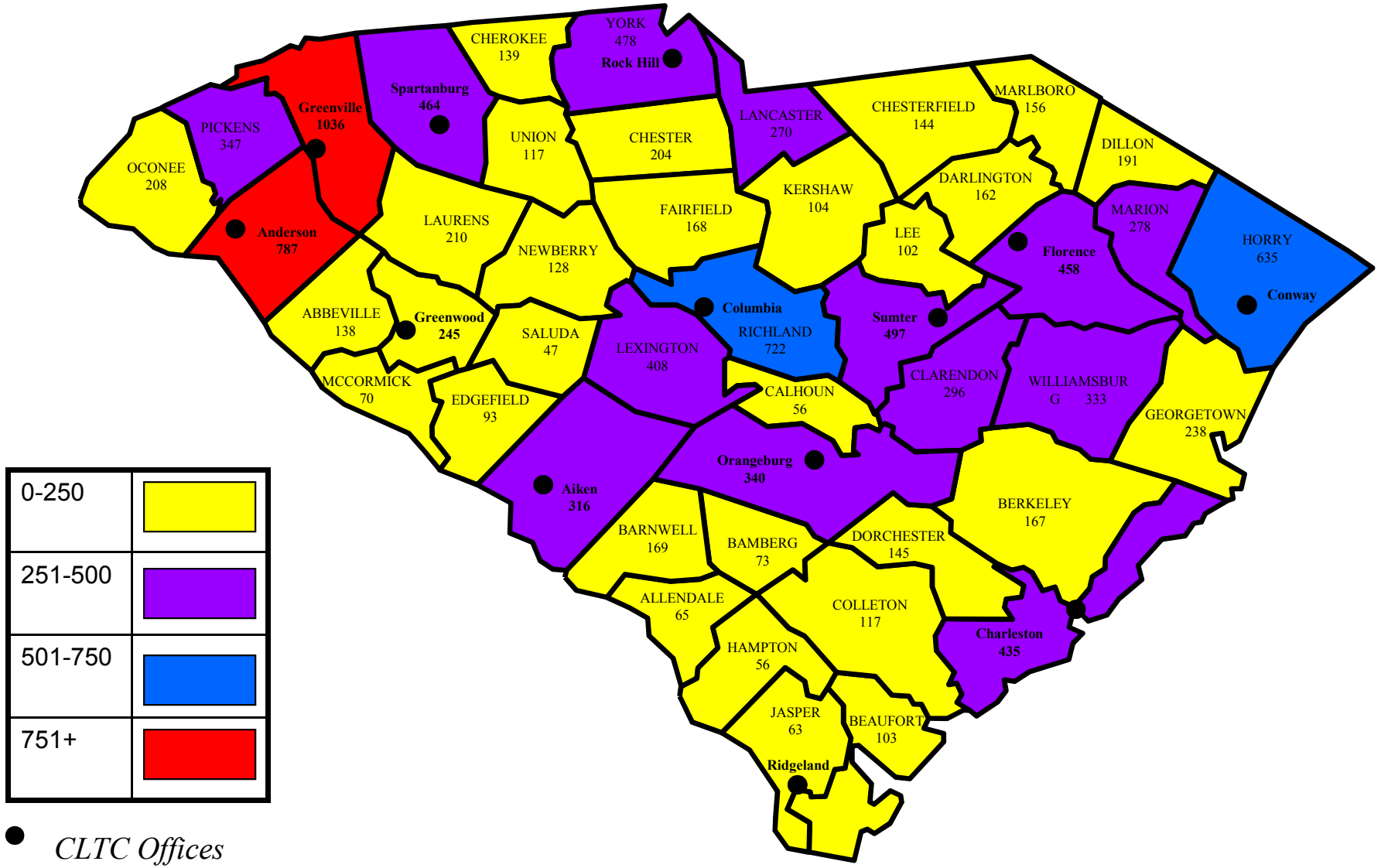


Open Authorization – Meals - April 2009

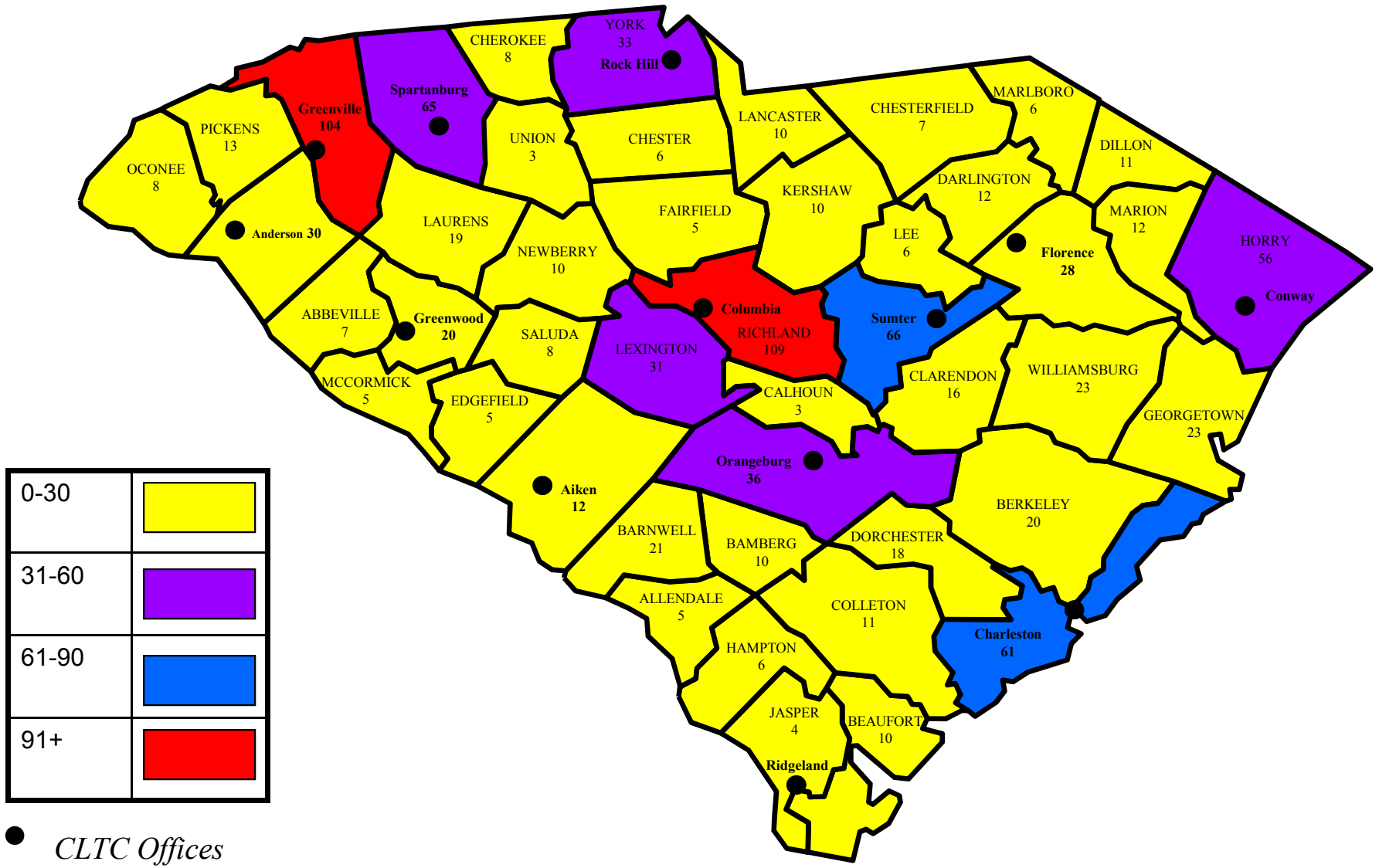


● *CLTC offices*

Community Choices Waiver Clients By County
April 2009



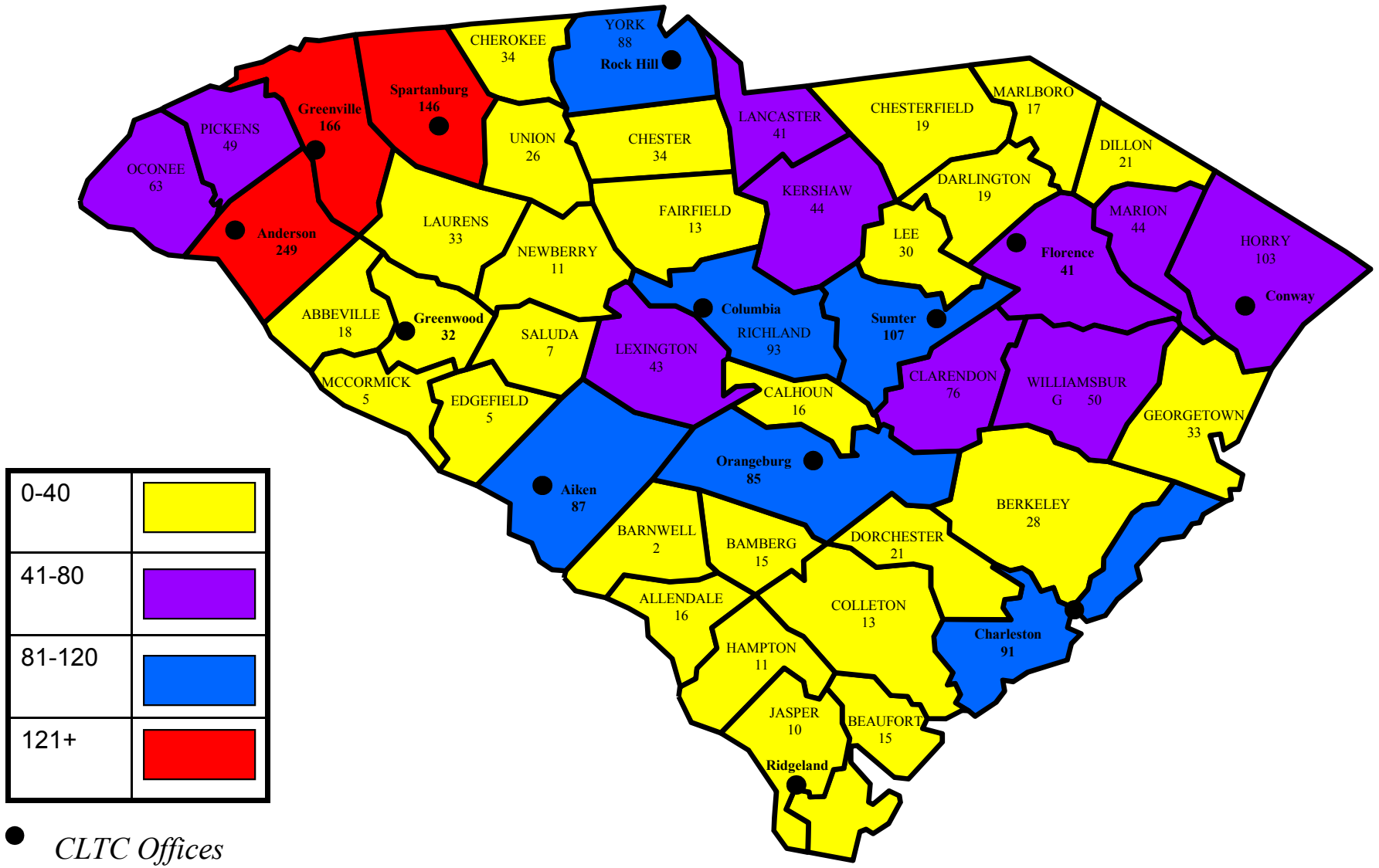
HIV/AIDS Waiver Clients By County
April 2009



State of CLTC

- Statewide Waiting List
  - In 2008, CLTC implemented a statewide waiting list.
  - Area offices no longer have a set number of "slots" for the Community Choices waiver.
  - In addition, each applicant receives a priority score, depending upon various factors.
  - Applicants with higher scores are higher on the waiting list.

CLTC WAITING LIST - March 2009



Contract/Scopes Changes

Contract/Scopes Changes

- All Providers
- In-home Services
- Adult Day Health Care
- Home Delivered Meals
- Case Management
- Reminders

Contract/Scopes Changes

- Scopes Changes - All Providers
  - Providers will be required to accept or decline a referral from CLTC or DDSN within two (2) working days.
  - Providers may use paperless filing systems that meet all current documentation requirements.
    - If using paperless filing systems, the provider must have a back-up system in the event the automated system is not available.

Contract/Scopes Changes

- Scopes Changes – All Providers
  - Services are not allowed when the participant is in an institutional setting such as hospital or nursing home. (Case management allowed under specified circumstances.)
  - All provider staff including administrative, nurses and aides/attendants will be required to have criminal background checks.

Contract/Scopes Changes

- Scopes Changes – All Providers
  - Providers will be required to name SCDHHS CLTC as certificate holder on general liability and workers' compensation policies.
  - Doing so replaces the requirement to submit evidence of insurance annually.

Contract/Scopes Changes

- Scopes Changes – All Providers
  - Providers will be required to check the CNA registry and the OIG Exclusions Web site for all staff.
    - CNA Registry – www.pearsonvue.com
    - OIG Exclusions List – http.//www.oig.gov/fraud/exclusions.asp

Contract/Scopes Changes

- Scopes Changes – In-home Services
  - Providers must have prior approval from CLTC if a participant requires more than one aide during the same time period. (PC II)
  - When there are two or more participants in the same home the provider must document and deliver the total number of hours authorized for each participant.

Contract/Scopes Changes

- Scopes Changes – In-home Services
  - Providers will be required to maintain office hours
    - Monday through Friday
    - 10:00 am - 4:00 pm
  - Providers must be available by phone
    - Monday through Friday
    - 8:30 am - 5:00 pm

Contract/Scopes Changes

- Scopes Changes – In-home Services
  - Providers will only be allowed to sub-contract with nurses for supervision and competency testing. (PC II)
  - Aides who are CNAs are required to complete competency testing. (PC II)
  - Providers will be required to use any Competency test developed by CLTC. (PC II)

Contract/Scopes Changes

- Scopes Changes – In-home Services
  - When there is a break in service of sixty (60) or more days, a new initial and 30-day supervisory visit is required. (PC II and PCI; initial visit also applies to nursing services.)

Contract/Scopes Changes

- Scopes Changes – In-home Services
  - When there is significant change in the participant's condition which results in a change in the service plan, the provider will be required to update the task sheet to reflect the new duties.

Contract/Scopes Changes

- Scopes Changes – In-home Services
  - All active participant records must contain at least two (2) years of documentation.
  - At least five (5) years of documentation must be maintained by the provider per Medicaid guidelines.
  - Children's Personal Care guidelines will be added to the Personal Care II Scope of Services.

Contract/Scopes Changes

- Scopes Changes – Adult Day Health Care
  - Providers will be required to allow participants to stay at the center for up to eight (8) hours when transportation can be arranged to allow this length of stay.
  - Providers will be required to obtain initial and subsequent physical forms (Form 122 DC) from the participant's physician.

Contract/Scopes Changes

- Scopes Changes – Adult Day Health Care
  - Upon receipt of Form 122DC, the provider will be required to notify the case manager that the form has been obtained; services will be authorized at that time.
  - Day care transportation scope will specify that providers are not required to provide ambulance transportation.

COMMUNITY LONG TERM CARE
ADULT DAY HEALTH CARE FORM

FROM: _____ ADHC

PARTICIPANT'S NAME: _____

SOCIAL SECURITY NUMBER XXX - XX - _____ MEDICAID NUMBER _____ DOB: _____

DIAGNOSIS: PRIMARY

(CURRENT) SECONDARY

MEDICAL HISTORY: _____

PHYSICAL EXAMINATION: T [ ] P [ ] R [ ] BP [ ]

LABORATORY DATA:

EENT:

RESPIRATORY:

CARDIOVASCULAR:

GASTROINTESTINAL:

GENITOURINARY:

MUSCULOSKELETAL:

SKIN:

ENDOCRINE:

ALLERGIES: _____

DIET:

SPECIAL CARE REQUIREMENTS: (List any daily activity limitations, special therapies or special care requirements):

Is the individual capable of self-administering their own medication(s)? [ ] Yes [ ] No

MEDICATIONS	DOSE/FREQ/ROUTE	MEDICATIONS	DOSE/FREQ/ROUTE

SIGNATURE OF ADHC STAFF DATE:

DATE SENT: INITIALS:

DHHS FORM 122 DC (revised 3/10/09)

CLTC Adult Day Health Care Form

Form 122 DC

Contract/Scopes Changes

- Scopes Changes – Adult Day Health Care
  - Providers of ADHC, Medicaid Nursing, and PCII will be required to verify nurse licensure and license status at the State Board of Nursing Web site.
    - http://www.llr.state.sc.us/pol.asp

Contract/Scopes Changes

- Scopes Changes – Home Delivered Meals
  - Providers will be allowed to deliver shelf-stable meals when requested by the participant or responsible party.
  - In the future, DHHS plans to update choice lists for meals providers to show the type of meals each agency offers (e.g., hot, frozen, shelf- stable).

Contract/Scopes Changes

- Scopes Changes - Case Management
  - Individual and Agency contracts will now be combined into one contract.
  - Language has been added about case managers being subject to individual reviews.
  - Based on these reviews: Providers may be suspended from receiving new referrals for a variable length of time depending on severity of the outcome of the review.

Contract/Scopes Changes

- Scopes Changes - Case Management
  - Language is being added to the contract to allow for a reduction or an increase caseload sizes of individual case managers based on the findings of the reviews.
  - Changes are being made in the Training section of the Scope: Requiring the 40 hours of training be completed within two (2) consecutive weeks of beginning of training and requesting no assignments of re-evaluations during the first 30 days of training of a new employee.

Contract/Scopes Changes

- Scopes Changes - Case Management
  - Language is being added to require team staffing within two days of acceptance of a referral of cases.
  - Case managers need to make referrals for all services, including incontinence supplies, before actually doing the authorizations.

Contract/Scope Changes

- Reminders
  - All providers and their staff are mandatory reporters for suspected abuse of adults and children.
  - All providers and their staff are required to maintain confidentiality of all participant information.

Contract/Scope Changes

- Reminders
  - Employees should not discuss one participant with another.
  - Providers should have more than one person trained at all times on Care Call billing. If one leaves or is out, there should be a backup person.

DDSN Update

DDSN Update

- Enrolling as a DDSN Provider
- Billing Options
- Claims Processing and Payment
- Common DDSN Edit Codes
- Provider Post-Payment Reviews
- New Developments

DDSN Update

- Enrolling as a DDSN Provider
  - If you have a contract with SCDHHS, this contract includes services to DDSN waiver participants.
  - DDSN is given a list of contracted providers and shares this information with appropriate county boards
  - All provider selection in the DDSN waivers is based on participant choice.

DDSN Update

- Billing Options
  - Electronic – Web Tool
    - Trading Partner Agreement (TPA)
    - http://www.hhs.gov/ocr/hipaa/assist.html
    - 1-888-289-0709
    - User guides and addenda
  - Hardcopy – CMS-1500
    - 08/05 CMS-1500 billing form
    - Forms must be purchased from an available vendor.

DDSN Update

- Billing Options
  - The required fields on the CMS 1500 that must be completed can be found in the Community Long Term Care (CLTC) provider manual in the billing section starting on page 3-9.
    - http://www.dhhs.state.sc.us/internet/pdf/manuals/cltc/Section%203.pdf
  - Claims should be mailed to the following address:
    - Medicaid Claims Receipt
      PO Box 1412
      Columbia, SC 29202-1412

DDSN Update

- Claims Processing and Payment
  - Remittance advice and payment is sent every Friday for claims that were processed during the previous week.
  - Your DDSN participants and your Care Call participants will be on the same remittance advice.
  - You may also access paid claims for your DDSN participants through the Care Call remittance advice report.

DDSN Update

- Common DDSN Edit Codes
  - 713 Edit - Frequency of billings exceeds allowable limits
    - Some procedure codes have edits that are based on a day's worth of service.
    - Bill each line of a claim on a daily basis, not by span date.

DDSN Update

- Common DDSN Edit Codes
  - 852 Edit - Duplicate date of service
    - A duplicate edit occurs on a claim if you have already been paid for the same procedure for the same date of service on a previously processed claim.
    - Check your remittance advice to ensure you have not been paid for the date in question. The date of payment can be found on the Edit Correction Form(s) located at the back of the remittance package.

DDSN Update

- Common DDSN Edit Codes
  - 853 Edit - Another provider has billed and been paid for the same service/date.
    - Double check the service authorization to ensure that you have the correct service and procedure.
    - You may also want to check with the service coordinator to ensure that two providers are serving this client at the same time.
    - If all information is correct and there are two providers serving this participant, refile the claim with the 76 modifier - repeat procedure same date of service.

DDSN Update

- Common DDSN Edit Codes
  - 950 Edit - Medicaid number not known or recognized
    - The Medicaid number on the claim is invalid.
    - Compare the Medicaid number on the claim to the one found on the service authorization.
    - If the Medicaid number is the same as the number present on the service authorization, contact the service coordinator for the correct Medicaid number.

DDSN Update

- Provider Post-Payment Reviews
  - At some point provider's cases will be audited.
  - Some recommendations to avoid recoupment:
    - Ensure that all task sheets are initialed daily and signed weekly by the family.
    - When billing claims, bill by the day and not the week this will ensure a clean audit trail between the claim that was billed and the task sheet the auditors review.
    - Pay attention to the service authorization making sure that the code(s) and units billed on the claim form match what was authorized by the DSN board.

DDSN Update

- New Developments
  - DDSN has been approved to operate a new waiver known as the Community Supports waiver.
  - The waiver will serve approximately 2,500 individuals at any one time .

DDSN Update

- New Developments
  - This waiver will offer the following services that will be authorized in the same manner as authorized in the MR/RD and HASCI waivers:
    - Personal Care I
    - Personal Care II
    - Adult Day Health Care
    - Adult Day Health Care Nursing
    - Adult Day Health Care Transportation

Additional Edit Codes

Additional Edit Codes

- Edit Code 976
- Edit Code 517
- Edit Code 883
- Edit Code 951

Additional Edit Codes

- Edit Code 976
  - Edit Code 976 - The participant has hospice on the date of service.
  - Resolution steps:
    - Contact the CLTC office to get the Hospice prior authorization number (PA#).
    - Place the PA# in field #7 (PC Coord) of the edit correction form. This needs to be in red ink.
    - Place the letters "PROV" in the upper left hand corner by the section Analyst id.
    - Return the ECF to the address located at the bottom of the form.

Additional Edit Codes

- Edit Code 517
  - Edit Code 517 - The participant is not in a waiver.
  - Resolution steps:
    - Contact the CM in the CLTC area office who faxed the authorization. Ask him/her why the participant is not in the waiver.
    - If the CM indicates that the participant is in the waiver, ask him/her to have the MMIS (Medicaid payment system) updated.
    - If the participant is not in the waiver, ask the CM why he/she has not sent you a termination.

Additional Edit Codes

- Edit Code 883
  - Edit Code 883 – A Care Call service was billed outside of the Care Call system.
  - Resolution step:
    - You will need to contact the CLTC central office with an explanation as to why you are billing outside the Care Call system.

Additional Edit Codes

- Edit Code 951
  - Edit Code 951 - The participant is not Medicaid eligible on the date of service.
  - Resolution steps:
    - Check Medicaid eligibility to ensure the participant is eligible. Do not assume that because you received an authorization from CLTC that the participant is Medicaid eligible.
    - Whenever it's determine the participant is eligible, contact the CLTC area office to have the claim re-exported through care call.
    - Do not return the edit code form. A new claim will be filed for you.

Provider Compliance

Provider Compliance

- Provider Compliance
  - Provider Reviews and Results
  - Ranking Providers

Provider Compliance

- Provider Compliance
  - Is the method used to ensure providers are following the scope of service requirements.
  - In April 2008 a new scoring process was initiated for all PCII and ADHC provider reviews.

Provider Compliance

- Provider Reviews and Results
  - Since April 2008 approximately 100 provider reviews have been scored.
  - Results of Reviews
    - 5 have received 30 day suspensions
    - 4 have received 60 day suspensions
    - 3 have received 90 day suspensions
  - All other providers were required to submit corrective action plans
    - No action was required for providers with a score of zero (0).

Provider Compliance

- Ranking Providers
  - In the future CLTC will develop a system for ranking providers.
  - Providers will be ranked among their peers using a method/system similar to the five (5) star method.
  - The provider's rank will be on the Provider Choice List that is given to participants.

Care Call Review

Care Call Review

- Accessing Care Call on the Web
- Provider Information
- E-mail Addresses
- Message Board
- Care Call Reports
- Exceptions
- ADHC and Meal Providers
- Case Management Providers

Care Call Review

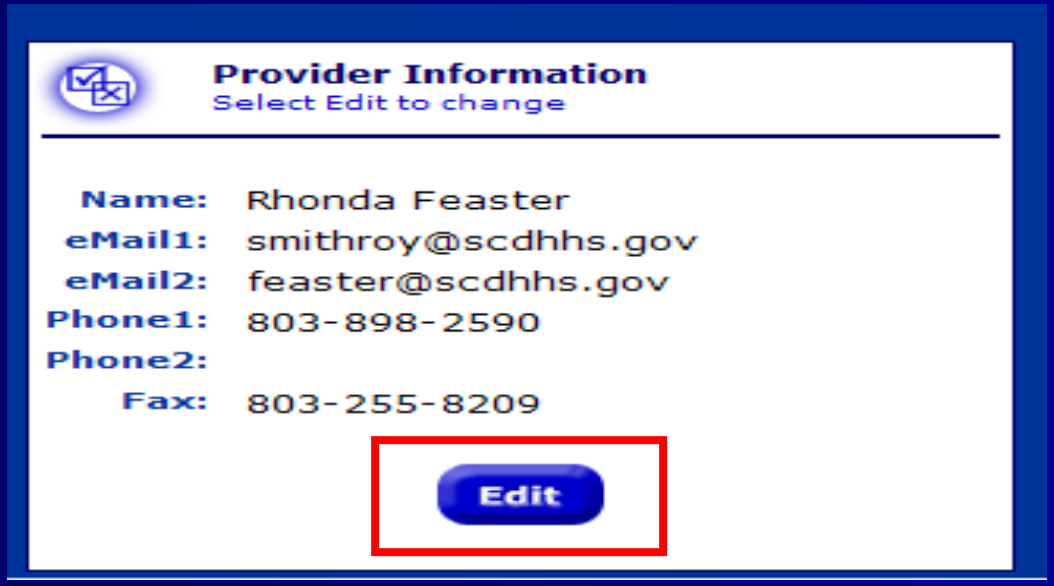
- Accessing Care Call on the Web
  - For an initial log-in password, contact Tony Matthews or Debora Carter.
    - 803-898-2590
  - Download a Care Call manual directly from the Web site.
    - https://scc.govconnect.com

Care Call Review

- Provider Information
  - After accessing Care Call for the first time and *periodically*, providers need to make sure the ***Provider Information*** in Care Call is correct.

Care Call Review

- Provider Information
  - If a phone number or e-mail address changes, the provider needs to edit the information in Care Call.



Care Call Review

- E-mail Addresses
  - CLTC is striving to go green and communicate with providers electronically 100% of the time.
  - CLTC uses the e-mail address in Care Call to send important information.
  - Providers must have an e-mail address in Care Call.
  - Providers are responsible for ensuring that their e-mail addresses are current.

Care Call Review

- E-mail Addresses
  - "Accept" e-mails with the extension @scdhhs.gov to avoid rejection as spam or junk mail.
  - Send CLTC e-mails to group e-mail IDs, not individuals e-mail addresses.
  - Use carecall@scdhhs.gov for problems related to Care Call.
  - Use provider@scdhhs.gov for provider or payment-related issues.

Care Call Review

- Message Board
  - On the Care Call log-in screen, messages may be posted to relay important information to providers.
  - Examples:
    - Alerts providers of known problems with the system
    - Notifies providers if claims will be submitted to MMIS early

Care Call Review

- Care Call Reports
  - Used to review and manage activities
    - Assist with claims resolution
    - Research payment-related issues
    - Monitor activities by in-home employees

Care Call Review

- Care Call Reports
  - Available via the web site
    - 24 hours a day/ 7 days a week
    - Contains (near) real-time, current information
    - Displays in four (4) different formats: web archive, Excel, comma delimited, and PDF

Care Call Review

- Care Call Reports
  - Preliminary Invoice Report
    - Provides detailed information about claims that were and were not submitted to MMIS for processing
    - Available for the most recent MMIS claim submission period only

Care Call Review

- Call Care Reports
  - Preliminary Invoice Report (continued)
    - Includes claims that were **submitted** to MMIS for processing and payment, regardless of when they were entered into Care Call
    - Includes claims entered since the last claim submissions that were **not submitted** to MMIS due to some critical exception condition

Care Call Review

- Care Call Reports
  - Provider Activity Report (Employee Activity Report)
    - Displays by employee all services performed during a given time period and the total dollars billed to MMIS for that employee
    - Includes the MMIS payment date and status code
  - Remittance Advice Report
    - Allows the provider to view and download detailed Care Call and MMIS payment information

Care Call Review

- Care Call Reports
  - SSN Worker Report
    - Used by providers to identify if the employee's social security number is already registered in Care Call
    - Indicates how many different times Care Call recognizes the SSN
      - This indicates if the employee has worked or is currently working for other agencies.

Care Call Review

- Care Call Reports
  - Unauthorized Phone Number Report
    - Lists all exceptions when an employee calls from a number that does not match any of the authorized numbers in our case management system
  - Overlapped Claim Report
    - For services requiring a check in and check out, this report indicates any occasion where an employee has checked in for two or more services or participants at overlapping times.
    - This would not include the valid case where an employee checks in for two services on one phone call.

Care Call Review

- Exceptions
  - In-home and Case Management providers should register employees prior to using Care Call for the first time.
  - If an employee checks into Care Call and is not registered, the claim will get an "I" exception.
  - Once the employee is registered, the "I" exception will be removed and no further action is required by the provider.

Care Call Review

- ADHC and Meal Providers
  - Providers need to document the total amount of service provided.
  - Examples:
    - If 9 meals are delivered to a participant and 7 meals are showing as being authorized, 9 meals need to be entered for the amount of service provided.
    - If ADHC-Nursing is provided for 3 days, and 5 days are showing as being authorized, 3 days need to be entered for the amount of service provided.

Care Call Review

- Case Management Providers
  - If a resolution is being completed due to case closure, service **"CL",** case closure needs to be indicated and not the normal activity that would have been performed that month.

Referral/Authorization Process

Referral/Authorization Process

- Referral/Authorization Process - Phoenix
  - Upcoming Changes
  - Impact on Providers
  - Phoenix Implementation

Referral/Authorization Process

- Upcoming Changes
  - Phoenix is CLTC's upcoming comprehensive participant tracking system.
  - Phoenix will replace CLTC's current Case Management System.
  - A system that tracks all authorizations and terminations for participants and providers.

Referral/Authorization Process

- Upcoming Changes
  - Case managers and nurses can
    - Electronically make referrals to providers for services
    - Electronically receive a response to a referral
    - Electronically send authorizations, terminations, and service plan to providers
      - Replaces current CMS fax capabilities

Referral/Authorization Process

- Impact on Providers
  - Phoenix will send providers e-mails stating they have a referral.
    - Providers must have internet access and an e-mail address.
    - Phoenix will use the email address in Care Call.

Referral/Authorization Process

- Impact on Providers
  - Phoenix will direct the provider to a web site to view the referral.
  - Providers will accept or decline the referral.
  - If the referral is accepted, providers will receive an e-mail directing them to a web site to retrieve the authorization and service plan.

Referral/Authorization Process

- Phoenix Implementation
  - Phoenix is being developed in stages and will be implemented in phases.
    - All stages may not be available in Phase 1.
  - The on-line implementation is planned for early 2010.
  - Provider training will be scheduled prior to implementation.

Resources

Resources

- Web sites
- Phone Numbers
- E-mail Addresses

Resources

- Web sites
  - South Carolina Medicaid
    - www.scdhhs.gov
  - South Carolina Medicaid Web-based Claims Submission Tool
    - www.webclaims.scmedicaid.com
  - South Carolina Medicaid Provider Outreach
    - www.scmedicaidprovider.org

Resources

- Web sites
  - South Carolina Department of Disabilities and Special Needs
    - http://www.state.sc.us/ddsn/
  - Care Call
    - http://scc.govconnect.com
  - Scopes of Services
    - http://www.scdhhs.gov/insidedhhs/bureaus/BureauofLongTermCareServices/BECOMINGAcltcPROVIDER.asp

Resources

- Web sites
  - CNA Registry
    - www.pearsonvue.com
  - OIG Exclusions List
    - http.//www.oig.gov/fraud/exclusions.asp
  - State Board of Nursing
    - http://www.llr.state.sc.us/pol.asp

Resources

- Phone Numbers
  - CLTC Central Office
    - 1-803-898-2590 – main phone
    - 1-803-255-8209 – fax number
  - South Carolina Medicaid Web-based Claims Submission Tool
    - 1-888-289-0709
  - South Carolina Department of Disabilities and Special Needs
    - 1-888-376-4636
  - Medicaid Automated Eligibility Verification
    - 1-888-809-3040

Resources

- Secure Emails
  - DHHS now has encryption software that allows CLTC to send emails with Protected Health Information (PHI).
  - If you receive an e-mail from CLTC and do not have the same encryption software as DHHS, you will receive a message with a secure link and instructions for creating a password to be able to retrieve the e-mail.
  - E-mail sent to DHHS from providers will not be encrypted and therefore should still not contain any PHI.

Resources

- E-mail Addresses
  - Provider Group
    - provider@scdhhs.gov
  - Care Call Group
    - carecall@scdhhs.gov

Questions?